CO RECOVER

CREDIT CARD AUTHORIZATION FORM

By signing below, I authorize CoRecover, LLC to keep the credit card information I have provided below on file and automatically charge this credit card for all fees I incur while I am a patient. In accordance with practice policies fees charged may include Professional service fees, Co-pays, Co-insurance, No show charges, and Administrative fees.

NOTE: For all appointments including your initial intake appointment we require 48 hours' notice of cancellation or a no-show charge of $150 will be applied.

Credit card type: [ ] Visa [ ] MC [ ] AmEx [ ] Discover

Card number: _____

Name on card: _____

Expiration date: _____

CCV Code: _____

Billing zip code: _____

Signature: _____ Date: _____

Print name: _____